QUESTION PRESENTED

Whether this Court will permit the Board to create a extra-statutory exclusion to the Act's definition of "supervisor" for health care professionals without any textual support in the Act or in the settled principles applying section 2(11) statutory criteria to all employers subject to the Act.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Table of Authorities Continued

Table of Authorities Continued

Table of Authorities Continued

IN THE

Supreme Court of the United States

OCTOBER TERM, 1993

No. 92-1964

NATIONAL LABOR RELATIONS BOARD,
Petitioner,

vs.

HEALTH CARE & RETIREMENT CORPORATION OF AMERICA,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

---

BRIEF OF U.S. HOME CARE CORPORATION OF HARTSDALE, NEW YORK, AS AMICUS CURIAE IN SUPPORT OF RESPONDENT

RULE 29.1 STATEMENT

Amicus Curiae U.S. Home Care Corporation is a publicly owned corporation. It has no parent company. Its subsidiary companies are identified as "U.S. Home Care" companies in each state of operation except New York where its subsidiary is "Affiliated Home Care of Westchester, Inc."

CONSENT TO FILING

This brief *amicus curiae* is filed pursuant to Supreme Court Rule 37.2 with the written consent of all parties. The letters of consent are filed with the Clerk of the Court.

INTEREST OF AMICUS

1. U.S. Home Care Company ("USHO") *amicus* is a leading nation-wide provider of integrated home health care services. Beginning in 1974 as a para professional organization specializing in home care aides in Westchester County, New York. USHO now serves over 48 million people in 11 major markets: Long Island, Metropolitan, and Upper Hudson Valley/ Albany, New York; Bridgeport, Hartford, New Haven, and Wallingford, Connecticut; Philadelphia and Pittsburgh, Pennsylvania; Detroit, Michigan; Baltimore, Maryland; Atlanta, Georgia; Los Angeles, California; and West Palm Beach, Port St. Lucie, Miami, and Fort Lauderdale, Florida.

2. USHO maintains its principle office and place of business at 141 South Central Avenue, Hartsdale, New York. USHO operates 26 locations in the markets noted above and employs approximately 3,500 health care professionals and para professionals as I.V. Certified, Registered Nurses, Registered Nurses, Licensed Practical Nurses, Home Health Aides, Personal Care Aides, Homemakers' Companions, Physical Therapists, Speech Therapists, and Occupational Therapists. During November, 1993, these health care professionals and para professionals provided quality care to 4,500 patients through 18,000 visits and 300,000 hours of service to patients in their homes. Because USHO has gross annual revenues in excess

of $100,000.00 annually, and receives goods valued at over $50,000.00 from points outside the state of New York, USHO is an employer engaged in commerce within the meaning of the National Labor Relations Act, 29 U.S.C. §152(2).

3. The Court's decision in this case will directly affect the quality of health care to nursing home patients and also to the increasing number of patients receiving care in their homes. In both in-patient and home care services, the interest of health care providers is identical: to maintain and develop the kinds of quality, affordable patient care likely to attract and retain patients. At USHO, the primary consideration is to care for the needs of each individual patient through qualified and committed caregivers. The chartered corporate goal is to improve the way we as care providers and as a society respond to the acutely and chronically ill, aged, and disabled.

4. USHO is the only party or *amicus* herein to present to the Court the unique perspectives of home health care providers and their patients. In the case of geographically dispersed home based patient care, the professional nurses who direct and evaluate the patient care provided by para professionals provide the only direction and monitoring of the quality of care at the patient's bedside. The Court's apparent decision to postpone a ruling in *Visiting Homemaker & House Services, Inc.* v. *NLRB* (No. 92-1799) (*certiorari* pending), a case directly involving a home health care provider, highlights the importance of the instant case because the outcome here may control the outcome in *Visiting Homemaker*.

STATEMENT OF THE CASE

A. Home Health Care

For more than 100 years home health care services in the United States have been provided by visiting nurses who substituted for busy medical doctors unable to make demanding and frequent house calls to terminally ill patients.[1] By 1963, the number of visiting nurses associations and home care aide organizations had reached 1,100.[2] In 1965, the enactment of Medicare provided federal payments for skilled nursing and curative therapy for patients over 65 years of age and disabled patients of any age. By 1993, this benefit increased the number of certified home health "agencies" to nearly 7,000.[3] Another 7,000 providers service patients in their homes as non-certified agencies because they provide only non-reimbursable Medicare services, or provide no skilled nursing care, or care for private-pay patients. Today, nearly 14,000 providers now deliver home care to approximately six million individuals suffering from

[1] Griffith, *The Home Health Agency: Past Present & Future, Caring*, Aug. '86, 12; *Basic Statistics About Home Care 1993, National Association for Home Care*, 1 (hereinafter "*Basic Statistics*").

[2] *Basic Statistics* at 1.

[3] Source: *HCFA, Office of Survey and Certification*. The term home health "agencies" includes, visiting nurses associations, combined government and voluntary agencies, state, county, city, and other local government-run agencies, proprietary for-profit companies, private non-profit companies, hospital-based agencies, skilled nursing facilities, and rehabilitation facilities. Less than 30% of the certified "agencies" are proprietary. In 1993, less than 8% of Medicare benefit payments were for care provided by home health agencies. *Basic Statistics* at 3.

acute illness, long-term conditions, permanent disability, or terminal illness with a variety of professionals, para professionals, and allied service personnel.[4]

Despite annual patient share growth rates estimated at 10% between 1986 and 1991 and 12% since 1991, home care remains only 3% of the national health care expenditures now in excess of $800 billion.[5] Thus, while the number of home care recipients has increased annually home health care is more cost effective than similar care provided in hospitals and nursing homes. For example, in 1993, home health charges per visit was $78.00, while skilled nursing facilities charges were $263.00 per day, and hospital charges were $1,514.00 per day.[6] In addition, significant cost savings are achieved whenever a patient is moved from institutional settings into their own homes.[7]

Several factors and trends project accelerated growth for home care providers. Our aging population is expanding: one out of every six (6) persons will be over the age of 65 by the year 2000.[8] As health care moves from being hospital centered into HMOs and community walk-in emergency centers, patient access to and the need for home care services will also increase. This population will include steadily expanding

[4] *Basic Statistics* at 1.

[5] Source: Office of National Health Statistics.

[6] *Basic Statistics* at 8.

[7] The average expense per home care visit rose only $17.00, from 1987 to 1993, from $49.00 to $66. *Basic Statistics* at 3.

[8] *Caring, supra*, note 1 at 14-15.

percentages of chronically ill or disabled persons who have survived life-threatening illnesses. Patients with cancer, arthritis, diabetes, heart and chronic pulmonary diseases, and Alzheimers can maintain their dignity and independence in their homes surrounded by supporting family, friends, and familiar surroundings. The rapid advances in portable technological devices enable home care providers to deliver complex care involving parenteinal nutrition, enteral feedings, respiratory/venilator care, antibiotic and other forms of intravenous therapy.[9] As technological developments allow more complicated procedures to be safely performed in the home the responsibilities of those professional nurses who direct and evaluate the home care delivered by aides and companions will increase. As specialized long-term services expand, these nurses will direct subordinates in the delivery of patient care programs with a greater complexity and variety of curative needs than is presently the case.

The most significant factor in the projected growth of patients receiving home care is overwhelming evidence of patient preference. A recent poll conducted by the American Association of Retired Persons showed that 85% of those middle age and older Americans responding prefer the receipt of health services in their homes rather than in nursing homes, clinics, or hospitals.[10] This preference is based upon the knowledge that home care is quality care delivered where patients can be in charge of their own recovery and treatments.

---

[9] *Id.* at 13.

[10] Straw, *Attitudes & Knowledge: Middle Age & Older Americans on Home Care, Caring*, March, 1992 at 78.

Public confidence in the quality care now provided and in the assurance of that quality in the future is undermined by the promulgation and acceptance of legal dogma like the Board's "mere patient care" rule that are based upon the unsupportable theory that only home health care professionals have an "interest" in the quality of home care provided.

B. The Public Interest in Patient Care

Home health care providers are pervasively regulated by federal, state, and local governments because of the paramount public interest in establishing and maintaining reliable and professionally competent health care. These statutes and regulations require quality health care as a condition of operation. Therefore, compliance with these requirements mandates that each home care provider's primary interest is in the quality of patient care delivered.

As the New York legislature stated: "the provision of high quality home care services to the residents of New York state is a priority concern."[11] The Maryland legislature has declared: "the purpose of home health care is (1) to avoid institutionalization, (2) to shorten hospital stays, (3) to speed recovery, and (4) to bridge the gap in community health services for patients who could not get adequate health care."[12] Pennsylvania's licensing requirements and other regulations have been enacted "to assure quality care

---

[11] Public Health Law §3600 (*McKinney's Consolidated Laws of New York*, Annotated, 1993).

[12] Annotated Code of Maryland §19-402 (1993).

deliveries in [home health care] facilities."[13] These and other states, provide for professional nurse direction and evaluation of the health care provided by home health aides.[14] Federal requirements imposed by Medicare upon certified home health providers mandate that "part-time or intermittent services of a home health aide" are to be provided "under the supervision of a registered professional nurse."[15] These supervisory requirements assure patients and their concerned families that they will not be mistreated or attended by unqualified professionals or non-professional care givers. Only home care providers who share with their care givers the mutual interest to maintain and exceed these requirements are entrusted with the responsibility for protecting these federal

---

[13] 35 P.S. §448.806(f) (Purdon's Statutes, 1993). *Accord*: West's F.S.A. (1993) §400.461(2) ("...to provide for the development, establishment, and enforcement of basic standards which will insure the safe and adequate care of persons receiving health services in their own home.").

[14] *E.g.*, Pennsylvania Administrative Code Sections 601.32(b), 601.35(c) (registered nurse "shall...supervise and teach other nursing personnel" including home health aides); Connecticut Department of Health Service Licensure Regulations §19-13-D69(4)(B) ("primary care nurse...is responsible for supervision of the services rendered to the patient and family by the homemaker-home health aide."); Florida Administrative Code, *Minimum Standards for Home Health Agencies*, Ch. 10D68.002(5) ("Home Health Aide is a person who provides personal health care services...under the supervision of a licensed health care professional..."); Public Health Law §3602.4 and .5 (*McKinney's Consolidated Laws of New York Annotated 1993*) ("Home health aide services" and "Personal care services" are to be "supervised by a registered professional nurse...").

[15] 42 U.S.C. §1395x(m)(1) and (4) (1993).

and state interests in quality (not as the Board has described it "mere") patient care.

C. Patient Care at USHO

Each USHO Branch Office is managed by a Director. In addition, each Branch Office employs a Director of Nursing who is in charge of clinical services. Each Branch Office also employs registered nurses (R.N.'s) as Field Supervisors who report to the Director of Nursing and who supervise patient care for a specific geographic area within the Branch Office.

The particular clinical services needed are determined in accordance with the orders of the patients' doctor(s). The R. N. Field Supervisor develops and implements the patient care plan, and, where no skilled nursing care is necessary, but para professional services are, supervises and directs the care given by the Home Health Aide and/or Personal Care Aides and/or Homemaker/Companion, and submits written evaluations of their work performance on an annual basis to insure that aides "are providing safe, high quality care to clients."[16] These evaluations determine whether these para professionals continue their employment with USHO. In addition, the R.N. Field Supervisor is responsible for compliance by all para professionals with USHO personnel policies and exercises this reprimand responsibility by unilaterally sending aides home, reassigning aides to different patients, limiting the type of patient the aide may attend, and effectively recommending other forms of discipline wherever violations of these USHO policies occur. The R.N. Field Supervisor is the only repre-

---

[16] *USHO Policy Manual*, Section 4.17 Supervision (1990).

sentative of USHO to direct and evaluate subordinate patient care at the homesite.

Where both skilled nursing services and para professional services are required by a patient, the foregoing responsibilities are exercised by Primary Care Nurses who are in charge of directing the care of each para professional assigned to the patient. Primary Care Nurses having these responsibilities report directly to the Director of Nursing. In these circumstances, the Primary Care Nurse is the only representative of USHO to direct and evaluate the patient care at the homesite. In some Branch Offices, Primary Care Nurses provided skilled nursing services, directly to patients in homes where no para professionals are assigned. In these cases, they exercise no supervisory or performance evaluation functions of para professionals.

In *Visiting Homemaker & House Services, Inc.*, 305 NLRB No. 90 (1992) (unreported) (reprinted No. 92-1799, Appendix A-16-A-19) (*certiorari pending*), the Board held that House Services full-time and regular part-time registered nurses who performed similar direction and evaluation functions of subordinates in patient's homes as those set forth above, were statutory "employees" under its notions about "mere patient care." This section 2(11) exclusion for health care supervisors is the same Board rule rejected by the decision below in the nursing home field.

SUMMARY OF ARGUMENT

1. The Board's notion that health care professionals who responsibly direct and evaluate others in "mere patient care" are not statutory "supervisors" within the literal language of section 2(11) of the Act was,

with good reason, rejected by the Court of Appeals. In 1947 Congress enacted a supervisory exclusion that does not differentiate among supervisors on the basis of their profession or occupation. Congress declined to enact any exemptions or exclusions for any group of professionals including professional nurses on the basis the Board proposes here.

2. The question presented for decision by this Court is answered by first reading the statutory elements of supervisory status in section 2(11), and second by applying these elements to the health care field as they would be applied to any other field covered by the Act. Nothing in the Act distinguishes health care supervisors from other supervisors. Universal application preserves for health care employers the same undivided loyalty from those who responsibly direct and evaluate the performance of subordinates that section 2(11), properly understood, confers upon all employers subject to the Act.

3. The Court of Appeals faithfully adhered to the Act as written by recognizing that those who responsibly direct and evaluate subordinates to accomplish their employers' business purpose are, under section 2(11) and long settled principles applied by the Board in other cases, statutory "supervisors." The Court of Appeals then properly overruled the Board by concluding that since "patient care" is the mission of heath care providers, those professional nurses who responsibly direct and evaluate subordinates in the performance of this mission are in law and fact "supervisors."

4. The decision below fully effectuates the Congressional purposes that led to the enactment of section 2(11) and the inclusion of professional nurses within

the Act's jurisdiction in section 2(12). The line drawn by the Court of Appeals preserves to the health care employer the undivided loyalty of those professional nurses who responsibly direct and evaluate subordinates in the delivery of the employers' mission: patient care. The decision below concurrently preserves to professional nurses who perform direct patient care or who demonstrate patient care techniques to subordinates the option of collective representation.

5. There is no source in the Act for the Board's sweeping exclusion from section 2(11) of all nurses whose direction of subordinates someone might label as "incidental" to "mere patient care." By misrepresenting the "uniformity" of its pre-1974 health care decisions, the Board uses inaccurate history to create a self-fulfilling prophesy. The Board then seizes upon 1974 Committee Reports and claims "authorization" for its present rule. This form of boot strapping does not constitute even Congressional Committee much less Congressional approval of the Board's present rule that was unannounced until after 1974. The Board has no roving commission to ignore what Congress did and instead adopt what it did not do.

6. This is not a factual dispute or a case where essential principles embodied in the Act are unaffected. Instead, the Board has concocted a statutory definition of "supervisor" which exempts nearly all professional nurses from supervisory status. No amount of "expertise" can save the Board's *ipse dixit*, without a source in the Act, that the responsible direction and evaluation of patient care by subordinates at the patient's bedside is *not* "in the employers interest" within the well-settled meaning of section 2(11).

ARGUMENT

I. THE COURT OF APPEALS APPLIED SECTION 2(11) AS ENACTED IN OVERRULING THE BOARD

Section 2(11) of the Act, unaltered since its enactment in 1947, defines the term "supervisor" as:

> "any individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, *or* responsibly to direct them, or to adjust their grievances, *or* effectively to recommend such action, if in connection with the foregoing the exercise of such authority. . .requires the use of independent judgement."(emphasis supplied).

Section 2(3) excludes "any person employed as a supervisor" from the definition of the term "employee." This statutory exclusion from the Act's coverage is written broadly. By its express terms section 2(11) excludes all "supervisors" including "professionals" as defined in section 2(12)[17] employed by any employer regardless of the business purpose of any employer subject to the Act's jurisdiction. Indeed, Congress in 1947 deliberately enacted provisions containing one statutory "supervisory" definition and provided no exemption from section 2(11) even for the construction, communication, printing, newspaper,

---

[17] Section 2(12) provides in relevant part: the term "professional employee means—(a) any employee engaged in work. . .(iv) requiring knowledge of an advanced type in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction and study in. . .a hospital. . . ."

mining and maritime industries where foremen were already union members.[18]

Congress specified that the same statutory exclusion would apply uniformly to all employers whose volume of business met the Act's jurisdictional standards. As required by separation of powers principles, the Court below necessarily applied this unitary statutory supervisory exclusion to the health care field as actually enacted by Congress. *Connecticut Nat. Bank v. Germain*, ___ U.S. ___ , 112 S.Ct. 1146, 1149-50 (1992) (the first cardinal canon is that courts must presume that the legislature says in a statute what it means). See also *Park 'N Fly, Inc. v. Dollar Park and Fly, Inc.*, 469 U.S.189, 194 (1985) ("Statutory construction must begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose".).

II. THE COURT OF APPEALS APPLIED WELL SETTLED PRINCIPLES IN CONCLUDING THAT NURSES WHO DIRECT AND EVALUATE THE PATIENT CARE PROVIDED BY SUBORDINATES ARE ACTING "IN THE INTEREST" OF THEIR HEALTH CARE EMPLOYER WITHIN SECTION 2(11) AS WRITTEN BY CONGRESS

There is no dispute that Congress' use of the disjunctive "or" in section 2(11) means that the exercise or possession of any one of the enumerated powers, including "responsibly to direct" others and to effec-

---

[18] Leiter, *The Foreman in Industrial Relations*, 51-81 (Columbia, 1948). *See also How Collective Bargaining Works 67* (The Twentieth Century Fund New York, 1942) (newspaper industry feared loss of loyalty of unionized foremen disciplined by their union for taking management's side in contract interpretation disputes).

tively evaluate their performance "in the interest of the employer," establishes a statutory "supervisor" as a matter of law.

It is also common ground that the 1947 Taft-Hartley Amendments underscored Congress' propelling intention to preserve for the employer the undivided loyalty of those who are assigned the responsibility to keep employees at their work, to see to it that they perform well, and to correct them when they are at fault. H.R. Rep. No. 245, 80th Cong., 1st Sess. 16 (1947) (H.R. 3020). *See also* S. Rep. No. 105 80th Cong., 1st Sess.(1947) ("unless this Congress takes action, management will be deprived of the undivided loyalty of its foremen"); 93 Cong. Rec. 3952 (1947) (remarks of Sen. Taft) ("it is impossible to manage the plant unless the foremen are wholly loyal to the management."). Accord: *NLRB v. Yeshiva University*, 444 U.S. 672, 682 (1980) ("an employer is entitled to the undivided loyalty of its representatives"); *Florida Power and Light Co. v. International Brotherhood of Electrical Workers*, Local 641, 417 U.S. 790, 806 (1974). As Professor Cox has noted, even psychological alliance with a union undermines the foremen's loyalty to management and places them in an untenable position of conflict of interest. Cox, *Some Aspects of the Labor Management Relations Act*, 61 Harv. L. Rev 1, 5 (1947).

Congress did not separately define the section 2(11) phrases "in the interest of the employer" or "responsibly to direct". The Court below has recognized in one of the earliest cases considering the 1947 Taft-Hartley Amendments that the statutory definition includes those individuals responsible for insuring that subordinates maintain the quality and safety stand-

ards their employers have set for products or services. *Ohio Power Co. v. NLRB*, 176 F.2d 385, 387 (6th Cir.), cert. denied, 338 U.S. 899 (1949). The Court noted that the phrase "responsibly to direct" means: "To be responsible is to be answerable for the discharge of a duty or obligation. Responsibility includes judgement, skill, ability, capacity, and integrity, and is implied by power." *Id.*[19]

The Board itself has recognized in the industrial setting that "leadmen" who oversee other employees "as well as checking on quality" are responsibly directing others in the interest of their employer and therefore are statutory "supervisors." *Mathews & Co.v. NLRB*, 354 F.2d 432, 435 (8th Cir. 1965), cert. denied, 384 U.S. 1002 (1966), *enfg.*, 149 NLRB 161 (1964). Both delegated responsibilities require the delegated power, judgement, and integrity that define a statutory "supervisor". The Court of Appeals here simply applied these same settled principles to nursing homes as the language of section 2(11) requires.

In the very first case asserting its jurisdiction over proprietary nursing homes, the Board applied traditional section 2(11) principles to professional nurses. In *University Nursing Home, Inc.*, 168 NLRB 263, 265 (1967), the full five member Board (Chairman McCullock, Members Fanning, Jenkins, Zagoria, and Brown) concluded that a LPN "charge" nurse supervising the work of three nursing aides and one orderly

[19] At least three federal circuit courts of appeals have adopted this standard. *Maine Yankee Atomic, etc. v. NLRB*, 624 F.2d 347, 361 (1st Cir. 1980); *Monongahela Power Co. v. NLRB*, 657 F.2d 608, 613 (4th Cir. 1981); *Arizona Public Service Co. v. NLRB*, 453 F.2d 228, 231 (9th Cir. 1971).

in changing bed linens, and bathing, feeding, massaging, and "otherwise caring for patients" in accordance with physicians instructions was a statutory "supervisor" within the meaning of section of section 2(11). This reliance upon the direction of the delivery of patient care by subordinates as falling well within the statutory phrases "responsibly to direct. . .in the interest of the [University Nursing Home]" applied settled section 2(11) principles and was the sole basis for the Board's decision. The *University Nursing Home, Inc.* holding that the direction of "patient care" provided by subordinates is the exercise of section 2(11) supervisory duties has never been expressly or impliedly overruled by the Board or the federal courts.[20]

The Board has also long recognized in the industrial setting that foremen who evaluate the performance of subordinates and whose evaluations are accorded "substantial weight" by their superiors in decisions that affect tenure and job assignments are statutory "supervisors." *General Telephone Co. of Michigan*, 112 NLRB 46 (1955). This principle has been upheld as the single indicia of "responsibly to direct. . .in the interest of the employer". *Id.* at 112 NLRB at 49

[20] The Board claims *Doctors' Hospital of Modesto, Inc.*, 183 NLRB 950 (1970) (Members Fanning, McCullock, and Jenkins), 489 F.2d 772 (9th Cir. 1973) is the "seminal" decision announcing its "mere patient care" exclusion. If so, this reversal of policy made no mention of the earlier and conflicting *University Nursing Home*, decided by the very same Board members. This unexplained reversal ignores the duty of the Board to offer reasons for disregarding its own precedents. *Oil, Chemical & Atomic Workers v. NLRB*, 806 F.2d 269, 273-74 (D.C. Cir. 1986) (failure to explain or even cite prior case warranted reversal of Board order).

n.17 (foremen are statutory "supervisors" even though they have no authority to hire, discharge, assign, promote, or discipline employees). *See also Eastern Greyhound Lines v. NLRB*, 337 F.2d 84, 89 (6th Cir.1964) (if *some* discipline is meted out on foremen's recommendation, the occasional recommendation is "effective" within the scope of section 2(11) and the foreman is a statutory "supervisor"); *NLRB v. Southern Airways Co.*, 290 F.2d 519, 524 (5th Cir. 1961) (superior's "consideration" of foreman's recommendation sufficient to make foreman a statutory "supervisory"). The Board has also applied this analysis to find that professional nurses who prepare performance evaluations on subordinates are statutory "supervisors". *Rockville Nursing Center*, 193 NLRB 959, 962 (1971).

The foregoing decisions demonstrate that those individuals who are charged with the responsibility to direct subordinates and evaluate the quality of their work at the job site have until recently been considered by the Board and the federal courts of appeals to be statutory "supervisors" whose undivided loyalty belongs to the employer. The Court below properly applied these precedents to the health care field.

Remarkably, the Board does not claim these supervisory responsibilities exercised by nurses are unimportant, or that their possession or exercise does not normally fall within the accepted and well settled principles defining a statutory "supervisor." Rather, the Board devalues any exercise of accepted supervisory responsibilities by professional nurses that relate in some way to the manner and means by which subordinates deliver "mere patient care." This broad extra-statutory rule rests on two contradictory "policy" assumptions. The first is that a health care provider qua employer does not have a statutory "interest" recognized by section 2(11) in the oversight of professional health care services on the theory that only the health care professionals and *not* their employer are concerned with patient care. In conflict is the hypothesis that the "interest" of the health care provider qua employer and of the professional nurses who supervise and evaluate patient care is identical as to the maintenance of professional standards so there can never be undivided loyalty at the patient's bedside. Neither of these propositions as Judge Friendly said in a different context: "is. . .,to say the least, of the sort that commands instant assent." *St. Regis Mohawk Tribe, New York v. Brock*, 769 F.2d 37, 41 (2d Cir. 1985), cert. denied, 476 U.S. 1140 (1986). Standing together as they do under the Board's decision here, the result is not only counter-intuitive but irrational.

The Court below and the Board itself recognize the operative reality that all health care providers as employers are vitally interested in the oversight and direction of patient care because: "Patient care (or 'mere patient care,' in the Board's phraseology) is the business of a nursing home." *NLRB v. Beacon Light Christian Nursing Home*, 825 F.2d 1076, 1079 (6th Cir. 1987). Accord: *St.John's Hospital & School of Nursing*, 222 NLRB 1150 at 1150 (1976) ("the primary function of a hospital is patient care"), modified on other grounds, 557 F.2d 1368 (10th Cir. 1977). It is no less true for home care providers than for hospitals and nursing homes that:

> the best interest of the employer [is] to try to do a superior job of serving the needs and

> interests of the employer's customers. . .[and] to provide the type of patient care likely to attract and retain nursing home patients.

Beverly California Corp. v. NLRB, 970 Fld. 1548, 1553 (6th Cir. 1992).

The direction and oversight of para professionals by professionals at the home site is essential to the maintenance of quality patient care services. The nurses responsibility is not limited to monitoring the patient care plan schedule or to insuring that the care plan procedures are performed on schedule or as needed. Instead, to paraphrase the words of the House Committee of Education and Labor, they must insure that the care services administered by aides and companions are "done well." H.R. Rep. No. 245, 80th Cong., 1st Sess. 16 (1947). In the health care field, the insistence by professional nurses that subordinates adhere to the employers' quality standards is the difference for health care providers between patient recovery or decline. It is the difference between being a health care provider and being unable to attract patients. And essential to the maintenance of these standards is the health care provider's continuing confidence that the professional nurses will steadfastly require subordinates to adhere to quality and safety patient care standards, and to promptly correct and downgrade in the evaluation system those subordinates who fail to meet these requirements.

It can not be presumed, as the Board does, that unionized professional nurses would *never* be tempted in the direction and evaluation of subordinates to compromise the employers' interest in order to "get right" with either their union or a union representing para professionals. The Board's presumption requires

the health care provider to assume the risk of divided loyalty at the patient's bedside. In 1947, Congress enacted the opposite assumption. *See Beasley v. Food Fair of North Carolina*, 416 U.S. 653, 661-62 (1973) (dual union-supervisor status that *might* impair loyalty to management motivated Congress in enacting section 2(11) Congress intended to foreclose even psychological alliance with a union. See Cox, 61 Harv. L.Rev. at 5.); *see also* n. 18, *supra*. Insuring the undivided loyalty of these bedside representatives is perhaps the most important delegation "in the employers interest."

This direction and evaluation of subordinates is *not* automated. Indeed, it is precisely because each home health patient has a unique medical history, different symptoms,and distinct physical and psychological needs that the direction of patient care is rarely routine or ministerial. At USHO each para professional, because of limited education and training, relies upon the experience of the professional nurse to direct them in the endless variety of rapidly changing patient care needs because they lack the skill to exercise independent judgment themselves. USHO relies upon the "judgment, skill, ability, capacity, and integrity" of its professional nurses in delegating to them the power to direct subordinates in the same way as non-health care employers. *See Ohio Power*, 176 F.2d at 387. The Board adopted this obvious reality in the provision of patient care in nursing homes in *Avon Convalescent Center, Inc.*, 200 NLRB 702, 706 (1972):

> . . .servicing elderly and sick patients where critical needs may momentarily require variation in standard procedures, the nurse responsible for the supervision of other

> nurses. . .must obviously be prepared to exercise her discretion in utilizing her training and experience and assign and direct employees placed under her authority more than clerically or routinely.

There is no logical or factual basis for the Board's sweeping "mere patient care" exclusion from section 2(11) that would deny USHO and other health care providers the undivided loyalty of its only representative at the patient's home. In contrast, the Court of Appeals position faithfully strikes the line set by Congress in Section 2(11). The Court, unlike the Board, accepts the reality that the direction and evaluation of patient care is undertaken not only for compliance with professional standards but also is in the interest of the health care provider whose sole business purpose is patient care. This common sense meaning for the section 2(11) phrase "in the employers interest" is the same as that applied to non health care employers who depend upon the undivided loyalty of those charged with the responsibility to insure the quality of the goods and services that define their employers business mission.

The Court of Appeal's textual application of the supervisory exemption in section 2(11) preserves to the health care provider, as the Congress intended in 1947, the undivided allegiance of those who direct and evaluate how subordinates perform patient care. The decision below fully effectuates this legislative purpose by providing coverage of the Act to those professionals who provide patient care or who assist,but not those who direct and evaluate, para professionals in patient care.[21]

[21] The Seventh Circuit too narrowly defines the statutory exemption by placing determinative reliance upon only two "guiding lights." *See e.g., NLRB v. Res Care, Inc.*, 705 F.2d 1461 (1983). While not irrelevant, limiting the scope of section 2(11) to "proper" ratios of supervisors to employees and to those supervisors who exercise disciplinary authority, deletes without Congressional authorization from section 2(11) all the other disjunctive indicia of supervisory status Congress intended to have full and equal effect. This denies the intent of Congress by allowing the Board's "mere patient care" rule to prevail in those instances where proper application of all the other indicia would preserve to the health care employer the loyalty of his frontline representative precisely as Congress intended.

III. THE BOARD'S "MERE PATIENT CARE" RULE IS INCONSISTENT WITH THE STATUTE AND IS IRRATIONAL AS APPLIED TO HEALTH CARE PROVIDERS

The Board insists that its unauthorized amendment which exempts from section 2(11) all health care professionals who direct and evaluate subordinates in "mere patient care" has been "expressly approved" by Congress, noted with apparent approval by this Court in *Yeshiva*, and, in any event, is the type of administrative legislating excused by its "expertise." None of these assertions alone or in combination sustains the Board's sweeping "mere patient care" amendment to the Act's supervisory exemption.

In 1974 the 93d Congress *declined* to enact a statutory amendment to section 2(11) urged by the American Nurses Association that would have declared professional nurses to be section 2(3) "employees".[22] Undaunted by this legislative history, the Board nevertheless ascribes Congressional assent to

[22] *Hearings on H.R. 1236 Before the Special Subcomm. on Labor of the House Comm. on Education and Labor*, 93d Cong.,1st Sess. (1973)(Statement of ANA official Alice L. Ahmuty urging adoption of "specific modification" of section 2(11) "as it relates to registered nurses.").

its "mere patient care" modification that creates the same section 2(11) exemption for professional nurses that Congress failed to enact in 1974. A more persuasive analysis of Congressional rejection of the ANA proposal is that Congress disagreed with the enactment of a separate exclusion for professional nurses either with legislation or by administrative agency "expertise".

The Board, without any supporting statutory language in the Act, purports to find it in Committee Reports.[23] These Reports advised only a continuation of pre-1974 Board precedent; none of which mentioned the broad "mere patient care" exclusion now before this Court. Assuming *arguendo* that the Board is correct that these Committee members were familiar with its pre-1974 health care cases, then these Committee members also knew that this body of cases included well settled principles of "supervisory" status now admitted by the Board as flatly "inconsistent with its blanket "mere patient care" standard. *See, e.g., Beverly Enterprises-Ohio d/b/a North Crest Nursing Home*, 313 NLRB No. 54 (Nov. 26, 1993) (overruling *Avon Convalescent Center, supra*, and *Rockville Nursing Center, supra*); *Beverly Manor Convalescent Centers*, 275 NLRB 943, 946 (1985) (direction and evaluation of subordinates "motivated by patient care needs" is not "supervisory" within section 2(11)). As demonstrated above, and now admitted by the Board in *Beverly Enterprises-Ohio*, pre-1974 administrative decisions included explicit recognition that the preparation of subordinates' evaluations[24] and the direction of health aides in patient care[25] were not only indicia of supervisory status within the scope of section 2(11), but also designated those professional nurses who exercised or possessed these authorities statutory "supervisors". There is no suggestion in the Committee Reports that these decisions or any others were disapproved.

[23] H.R. Rep. No. 1051, 93d Cong. 2d Sess. (1974); S. Rep. No. 766, 93d Cong. 2d Sess. (1974).

Because the present *per se* rule was not found in Board "law" prior to 1974, it could not have been discovered by any member of the 93d Congress. It is both wrong and disingenuous to claim the Congressional Committees, much less the Congress, "approved" what is in fact a post-1974 administrative amendment to section 2(11) that implants a proposed amendment that Congress failed to adopt in 1974. *Tennessee Valley Authority v. Hill*, 437 U.S. 153, 193 (1978) (Statements of Senate and House Appropriations Committee members represent only their individual views and are not reliable evidence that Congress as a whole was aware of a federal agency position that the Tellico Dam project did not violate the Endangered Species Act).

The only reliable assumption, given the fact that Congress made no mention of specific Board health care cases in the Committee Reports, is that the Committee members were unfamiliar with the pre-1974 criteria for determining supervisory nurses in health care cases. Accordingly, the Reports lack any plau-

[24] *See Rockville Nursing Center*, 193 NLRB 959, 962 (1971).

[25] *See Avon Convalescent Center, Inc.*, 200 NLRB 702, 706 (1972); *See also University Nursing Home, Inc.*, 168 NLRB 263, 264 (1967) (cited with apparent *approval* in *Beverly Enterprises-Ohio*, 313 NLRB No. 54 (sl.op. fn. 4).

sible basis for the inference that the Board's present rule or it origins were known and thereby adopted or even approved by the Committees.

Because there is no basis for the Board's assumption about the Committees' familiarity with its pre-1974 health care decisions, the one legitimate legislative fact is that Congress declined to enact a broad exclusion for nurses from section 2(11). *See Mitsugi Nishikawa v. Dulles*, 356 U.S. 129, 135 (1958) (one "clear" indication of legislative intent was House Committee's rejection of proposed statutory amendment). It is also well settled that legislative histories including committee reports that do not result in the enactment of specific statutory language have little weight in divining the intent of Congress. *Public Employees Retirement System of Ohio v. Betts*, 492 U.S. 158, 168 (1989); *United States v. American College of Physicians*, 475 U.S. 834, 846-47 (1986) (The Court is "hesitant to rely on that inconclusive legislative history either to supply a provision not enacted by Congress or to define a statutory term enacted by a previous Congress."). The Board has no delegated or inherent authority to create a statutory exclusion Congress has declined to enact.

The Board and its *amici* erroneously insist that this Court's *Yeshiva* decision has prejudged this case by concluding that the "mere patient care" rule was "expressly approved" by Congress in 1974. Actually this Court decided that case without examining the status of the Yeshiva faculty members, not to mention nurses or health care professionals, under section 2(11) of the Act. 444 U.S. at 682. Thus, the propriety of the Board's present interpretation of section 2(11) and its application to health care supervisors were not

considered by the Court as the issue was not presented in *Yeshiva* at all. As noted above, the 1974 Senate Report cited by the Court (444 U.S. at 690 n. 30) cannot by any stretch of logic or imagination endorse the Board's post-1974 per se rule and neither did this Court in *Yeshiva*.

What the Court did consider and reaffirm in *Yeshiva* in evaluating both the Act's managerial and supervisory exclusions is that "an employer is entitled to the undivided loyalty of its representatives." *Id.* Consistent with fundamental separation of powers principles, the Court of Appeals faithfully gave full force and effect to section 2(11) "as written by Congress" (987 F.2d. at 1261) and properly rejected all Board claims of Congressional approval based upon a proposed health care exception for nurses that was not enacted. *Iselin v. United States*, 270 U.S. 245, 250-51 (1926)(the approval of legislative changes not enacted or intended by Congress "transcends the judicial function").

The Board's argument for its "mere patient care" exemption to section 2(11) is thus reduced to its claim of "expertise." This is the same "expertise" invoked in *Yeshiva*. There, this Court rejected the Board's wayward interpretation of the statutory exclusion for "managerial" personnel that conferred statutory "employee" status upon nearly all university and college faculty members. There, as here, the Board sought deference for its rule upon its claim to "expertise." This approach was designed to shield from judicial scrutiny the Board's unsupported, conclusory *ipse dixit* that the interests of the faculty and the university *qua* employer in education are so different and adverse as to uniformly and invariably render faculty

members "employees" rather than "managerial" personnel. This Court dismissed this "distinction," concluding instead that a university and its faculty actually share a common interest in education- the very purpose of a university. 444 U.S. at 686. This Court noted that faculty decisions are part of their university's interests, even assuming potential disagreement, because faculty decisions about tenure and curriculum define the university as an educational institution. *Id.*

This reasoning supports the Court of Appeals discussion in this case, because the direction and critical evaluation of subordinates' delivery of health care is no less in the interest of the health care provider *qua* employer because the nurses' maintenance of quality patient care provided by subordinates defines their employer as a health care provider. USHO relies upon the professional nurses' oversight and direction of the aides, companions, and therapists it employees in the patient's home to secure the common objective: quality patient care.

The Board's drawing of an artificial wedge between the common interests of health care professionals who direct and evaluate others and their health care employers also disregards the uncontrovertible and dominate Federal and state interest in the creation of private sector health care providers dedicated to quality who can consistently deliver high quality, low cost home health care to many Americans (*see infra* pp. 7-9). By ignoring the public expectation that the highest patient care standards will be insisted upon by all certified home health care providers, the Board affronts important public values in maintaining health

care standards and thus forfeits any basis for judicial deference to its claims of "expertise."

The Board's narrow focus on a rule that preserves for nurses' unions the widest possible pool of candidates treats patients and their concerned families "as impersonal categories or classes," mere customers whose interests in recovery are of no consequence. Mr. Justice Blackmun was wary of this same type of tunnel vision in *Beth Israel Hospital v. NLRB*, 437 U.S. 483, 508-09 (1978) ("I entertain distinct doubts about whether the Board, in its preoccupation with labor-management problems, has properly sensed and appreciated the true hospital operation and its atmosphere and the institution's purpose and needs.") (concurring opinion). This same "preoccupation" has infected the Board myopic vision of the actual delivery of patient care by nursing homes and home health care providers. The Board's irrational and misconceived "mere patient care" amendment to section 2(11) is capricious as a matter of law.

CONCLUSION

For the foregoing reasons, it is respectfully submitted that the Court of Appeals correctly set aside the "mere patient care" exclusion as contrary to the Act and as lacking any rational support in law, logic, or experience.

Respectfully submitted,

WILLIAM H. DUROSS, III
(Counsel of Record)
Suite 500
1255 23rd Street, N. W.
Washington, D. C. 20037
(202) 857-2948

Of Counsel:

SHAINIS & PELTZMAN
Suite 500
1255 23rd Street, N. W.
Washington, D. C. 20037
(202) 857-2946

December, 1993